PA04-2002: WEIGHT REDUCTION REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX OR MAIL TO:
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO BOX 25719
RICHMOND VA 23286-8212
FAX # 1-800-390-0109

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER:_____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
_____
OFFICE PHONE NUMBER ( ) _____- _____
REQUESTER NAME: _____ RN /MD /R.PH / ____
PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____
DRUG REQUESTED : _____ STRENGTH _____MG
REQUEST TYPE: (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE: _____
DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) UNITS / RX _____ DOSING FREQUENCY: _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

OBESITY –INITIAL EVALUATION

ICD9 CODE :

MUST HAVE SUPPORTING INFORMATION AND EVIDENCE OF CO-MORBIDITY:

Body Mass Index (BMI) _____kg/m2
Client Weight_____
Client Height _____
Diabetes Mellitus _____
Hypertension _____
Hyperlipidemia _____

APPROVAL OF REQUEST: _____ INITIAL COVERAGE MONTHS 1-3

OBESITY -- CONTINUOUS COVERAGE MONTHS 4 - 6

ICD9 CODE :

MUST HAVE EVIDENCE OF SUCCESS: EVIDENCE OF 4 LB. WEIGHT LOSS AT END OF 1ST MONTH

Weight at start of Treatment _____
Weight at end of 1st month _____
Total weight loss for1st month _____

MUST MAINTAIN OR EXCEED 1ST MONTH WEIGHT LOSS AT THE END OF 3RD MONTH .
Weight at end of 3rd month _____

APPROVAL OF REQUEST: _____ COVERAGE MONTHS 4-6

OBESITY -- CONTINUOUS COVERAGE MONTHS 7 – 11

ICD9 CODE :

MUST HAVE EVIDENCE OF SUCCESS: EVIDENCE THAT WIGHT LOSS AT END OF MONTH 3 IS MAINTAINED OR EXCEEDED

Weight at end of 3rd month _____

MUST HAVE EVIDENCE OF SUCCESS: EVIDENCE THAT WIGHT LOSS AT END OF MONTH 6 IS MAINTAINED OR EXCEEDED

Weight at end of 6th month _____

APPROVAL OF REQUEST: _____ COVERAGE MONTHS 4-6

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ **APPROVED**_____
DENIED _____
PENDING ADDITIONAL INFORMATION_____
DATE /TIME OF RECEIPT _____
DATE/TIME RESPONSE _____
REVIEWER _____
COMMENTS:

RI PRIOR AUTHORIZATION CALL CENTER
FAX NUMBER 1-800-390-0109 *(AVAILABLE 24 HOURS)*
TELEPHONE NUMBER 1-866-420-3874

RI Prior Authorization - Call Center Hours
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
SATURDAYS 9:00 AM – 1:00 PM (EST)